Texas Department of Insurance, Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Requestor's Name and Address: SOUTH TEXAS RADIOLOGY GROUP 8401 DATAPOINT DRIVE SUITE 600 SAN ANTONIO, TX 78229	MFDR Tracking #: M4-09-5834-01
Respondent Name and Box #: MITSUI SUMITOMO INSURANCE USA Rep Box # 19	

PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPAL DOCUMENTATION

Requestor's Position Summary: "We received from the patient regular health insurance at the time of service. Then we received workers compensation billing information from the regular health insurance to bill (see attachment b). This is when we billed to workers compensation."

Principal Documentation:

1. DWC 60 package
2. Total amount sought - $82.44
3. CMS 1500
4. EOB's
5. Operative Report

PART III: RESPONDENT'S POSITION SUMMARY AND PRINCIPAL DOCUMENTATION

Respondent's Position Summary: "This is a medical fee dispute concerning bills for x-rays performed on April 13 & 14, 2008. Requestor initially billed a health insurer for these services. Requestor first billed the Respondent on September 8, 2008. This date was more than 95 days from the date of service. Accordingly, the bill was denied based on the Requestor's failure to timely submit it bill pursuant to Texas Labor Code section 308.027(a)."

Principal Documentation:

1. DWC 60 package

PART IV: SUMMARY OF FINDINGS

Eligible Dates of Service (DOS)	CPT Codes and Calculations	Denial Codes	Part V Reference	Amount Ordered
4/13/08	72192-26	29, R25, B13, R01	1-6	$70.64
4/14/08	71010-26	29, R25, B13, R01	1-5, 7	$11.79
Total /Due:				$82.43

PART V: REVIEW OF SUMMARY, METHODOLOGY AND EXPLANATION

Texas Labor Code Section 413.011(a-d), titled *Reimbursement Policies and Guidelines*, and Division Rule 134.203, titled ***Medical Fee Guideline for Professional Services*** effective for professional medical services provided on or after March 1, 2008, set out the reimbursement guidelines.

1. These services were denied or reduced payment by the Respondent with reason codes:
   - "29-Time limit for filing claim/bill has expired;
   - R25-Procedure billing restricted/see state regulations;
   - B13-Payment for services may have been previously paid; and
   - R01-Duplicate billing."
2. Per Section 408.0272 titled Certain Exceptions for Untimely Submission of Claim, subsection (b) states, "Notwithstanding Section 408.027, a health care provider who fails to timely submit a claim for payment to the insurance carrier under Section 408.027(a) does not forfeit the provider's right to reimbursement for that claim for payment solely for failure to submit a timely claim if: (1) the provider submits proof satisfactory to the commissioner that the provider, within the period prescribed by Section 408.027(a) erroneously filed for reimbursement with: (A) an insurer that issues a policy of group accident and health insurance under which the injured employee is a covered insured." The Requestor originally billed the claimant's private health insurance as evidence from EOB dated 5/19/08. The private health insurance denied reimbursement because it was not covered under that plan. On 8/11/08, the claimant called the provider and informed them that it was a workers' compensation injury. The Requestor then billed the Respondent within 95 days as evidenced from the EOBs that indicates they received bills on 9/4/08. Therefore, per Section 408.0272 the exception applies and the bill was submitted timely.
3. The Respondent denied reimbursement based upon duplicate claim/service. The disputed service was a duplicate bill submitted for reconsideration of payment. The Respondent did not provide information/documentation of duplicate payments. Therefore, this payment denial reason has not been supported.
4. Per review of Box 32 on CMS-1500, zip code 78229 is located in Bexar County. The maximum reimbursement amount, under Rule 134.203(b), is determined by locality. The Medicare conversion factor for Bexar County (Rest of Texas) is 38.087.
5. The DWC conversion factor for professional services provided in a office setting by a physician is 52.83.
6. Per 28 Texas Administrative Code Section 134.203(b), the MAR for CPT code 72192-26 is:

   DWC conversion factor of 52.83 divided by Medicare conversion factor of 38.087 = $1.39 X Medicare allowance of $50.93= $70.64. The insurance carrier paid $0.00. The Requestor is due the difference between the MAR and amount paid of $70.64.
7. Per 28 Texas Administrative Code Section 134.203(b), the MAR for CPT code 71010-26 is:

   DWC conversion factor of 52.83 divided by Medicare conversion factor of 38.087 = $1.39 X Medicare allowance of $8.50= $11.79. The insurance carrier paid $0.00. The Requestor is due the difference between the MAR and amount paid of $11.79.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES

Texas Labor Code Section. 413.011(a-d), Section. 413.031, Section. 413.0311, Section 408.0272 and Section 408.027
28 Texas Administrative Code Section. 134.1
Texas Government Code, Chapter 2001, Subchapter G

PART VII: DIVISION ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Section 413.031, the Division has determined that the Requestor is entitled to reimbursement. The Division hereby **ORDERS** the Carrier to remit to the Requestor the amount of $82.43 plus applicable accrued interest per Division Rule 134.130, due within 30 days of receipt of this Order.

ORDER:

Authorized Signature	Medical Fee Dispute Resolution Officer	10/5/09 Date

PART VIII: YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division Rule 148.3(c).

Under Texas Labor Code Section 413.0311, your appeal will be handled by a Division hearing under Title 28 Texas Administrative Code Chapter 142 Rules if the total amount sought does not exceed $2,000. If the total amount sought exceeds $2,000, a hearing will be conducted by the State Office of Administrative Hearings under Texas Labor Code Section 413.031.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.